MASSACHUSETTS

October 27, 2008

Health Care Quality and Cost Council
2 Boylston St., 5th Floor
Boston, MA 02116
Attn: Katharine London, Executive Director

Dear Ms. London:

I am writing to offer testimony on behalf of Blue Cross Blue Shield of Massachusetts (BCBSMA) to the Health Care Quality and Cost Council (QCC) with respect to its 2008 Reporting Plan. BCBSMA is a strong supporter of the Council's efforts to bring important information on health care cost and quality to Massachusetts consumers, and applauds its efforts to that end. We do have concerns that the methodology used to display cost information may produce unintended adverse results, and we urge the Council to make changes to address that potential outcome prior to its initial reporting of cost data. Our thinking and suggestions on this have been detailed in correspondence with you beginning mid-August (copies appended), and will be summarized and updated here with our current thinking and suggestions.

If the reporting plan proceeds to display results based on claims-level analysis, with reporting of median charges for both inpatient and ambulatory procedures as anticipated, BCBSMA's contracted rates with providers will be disproportionately revealed. I will explain in a moment why this is problematic for the state and counter-productive to efforts to contain healthcare costs through transparency, but first let me note two types of changes that the Council could make to mitigate this.

The first is to report mean, rather than median charges for providers. This would not require any restructuring of the underlying analyses – but rather a reporting of the average (mean) as opposed to the median. This would be a simple change – easily accomplished without any significant impact to the Council's reporting timeline, and would materially address the BCBSMA concern about disproportionately reporting our contracted rates (vs. those of other payors).

The second type of change that would address the problem is to re-structure the analyses such that the unit of analysis for each provider is the set of contracted rates with each payor for the services that will be reported – rather than at the level of individual claims paid to that provider. As outlined in the documents that we have shared with your office, we believe that reporting the mid-point of each provider's contracted rates for the services of interest provides a more meaningful indication to the consumer of the price that a provider charges, and how that price compares with that of other providers. While we understand the Council is reluctant to undertake a restructuring of the data for this round of reporting, I would urge you to consider this approach for future rounds. One important advantage of this approach is that, if the Council so chose, it could accomplish this method without the collection and analysis of the vast claims-level datasets currently being submitted. Instead, plans would simply report to the Council each of their contracted rates for the services of interest (i.e., services whose prices would be reported publicly). This could represent a considerable savings to the state and would not in any way impede the state's ability to report cost and quality data, as it is directed to do. For quality metrics, the Council could continue to rely on the multi-payer claims-based metrics compiled by both Massachusetts Health Quality Partners (MHQP) for ambulatory care and by the Division of Health Care Finance and Policy (DHCFP) for inpatient care.

Now let me explain the adverse impact that the current reporting plans for cost data (median charges for each service by provider) will have on health care pricing in the state. BCBSMA's strong market share, in addition to the inclusion of our self-insured claims (information we voluntarily reported, while other health plans did not), means that, for many providers, the majority of claims in the database will be BCBSMA claims. Further, we suspect that at the 50th percentile, an extraordinarily high percentage of the claims are BCBSMA claims, a percentage that is significantly disproportionate to our market share.

This disproportionate weighting in the claims will arm health care providers with inside proprietary information on just one of the state's health insurance payors and will allow them to alter their rate negotiations in order to increase payment rates. Disclosing only one payor's contracted rates will impose an anti-competitive effect, which is both unfair to businesses in a competitive industry and injurious to consumers and the state, which would have to pay higher rates. This is clearly not the result intended by the agency tasked with containing health care costs in Massachusetts.

By changing the way data are displayed – in the short-term, by reporting mean vs. median charges, and in the longer term, considering an alternative to claims-level analysis -- the Council can report meaningful data to consumers while retaining the confidentiality of proprietary, and potentially disruptive, plan-specific information.

We recognize the significant time, effort, and thought that the QCC has devoted to developing this important and beneficial tool, and want to be sure it will achieve the desired outcomes with a minimum of unintended consequences. Thank you for your hard work, and please do not hesitate to contact me if you have any questions.

Sincerely,

Dana Gelb Safran, Sc.D.
Vice President
Performance Measurement & Improvement
Blue Cross Blue Shield of Massachusetts

Associate Professor of Medicine
Tufts University School of Medicine

cc: Secretary, JudyAnn Bigby, Chair

Attachments:

1. Letter dated October 1, 2008 to the Honorable JudyAnn Bigby, MD Secretary

MASSACHUSETTS

October 1, 2008

Honorable JudyAnn Bigby, M.D., Secretary
Executive Office of Health & Human Services
One Ashburton Place, Room 1109
Boston, MA 02108

Dear Secretary Bigby, Judy

We are writing to you about an important issue that has potential, negative ramifications for Massachusetts health care consumers and Blue Cross Blue Shield of Massachusetts (BCBSMA), among others. As you know, BCBSMA believes that the most promising way to slow health care costs over the long-term is by improving the quality, safety, and effectiveness of the care patients receive. We, like other stakeholders and the Massachusetts Health Care Quality and Cost Council (QCC) itself, believe that public reporting of cost and quality information has a critical role in enabling the commonwealth to achieve vital improvements in health care cost and quality. Thus, we remain fully supportive of the QCC's efforts to advance public reporting of quality and cost data, and indeed, have contributed importantly to the thinking and principles adopted by the QCC to guide its choice of measures and public reporting activities. It is for this reason that we must raise our serious concerns about some critical elements of the planned approach to the public reporting of cost data by the Massachusetts Health Care Quality and Cost Council (QCC). For ease of reference, attached is a memorandum sent by Dana Safran, Vice President of Performance Measurement & Improvement at BCBSMA, to Katharine London and John Freedman on August 14, 2008.

Let us say from the outset that BCBSMA fully accepts the reporting framework that the QCC has selected – whereby provider-level costs for specific health care services (e.g., colonoscopy) will be compared with statewide costs, based on comparison of median amounts (provider vs. state) for each service. Moreover, we fully accept the report design that will afford "drill-down" information showing the provider's *range* of costs based on 15th and 85th percentile amounts. Like, the QCC, we hope that the public reporting of comparative cost data will help consumers make more informed decisions regarding where to obtain their care.

Our sole concern with the QCC cost reporting effort centers on the conduct of the analysis using claims-level data for each provider, rather than product-level data. This choice of analytic structure is problematic for a number of reasons. First, defining provider-level costs for specific services using claims-level data rather than product-level data produces information that does not optimally serve the QCC's goal of informing individuals about cost differences across providers. A product-level analysis would do this simply, directly and mathematically correctly by defining a provider's median cost for a service based on that provider's range of negotiated

rates for that service (with individual payers). By contrast, a claims-level analysis distorts information about provider-level cost differences by factoring in not just the provider's negotiated rates for the service, but the number and mix of patients to whom that service has been provided. In modeling results provided to Katharine London and staff (memo attached), as well as in examination of select examples of data that Ms. London provided to BCBSMA, it is clear that claims-level vs. product-level analysis of cost data yield a different answer as to a provider's median cost – and how that compares with the state median cost. Because the QCC has not been made aware of this fact, and because we have demonstrated that the decision regarding analytic structure will materially change the provider-level cost information to be reported, we urge you to take time to understand and discuss this issue.

A second highly problematic feature of employing an analytic structure that uses claims-level data to identify provider-level service costs is that we believe it has the result of disproportionately exposing BCBSMA negotiated rates to the public, to providers, and to our competitors. While we have not yet had access to substantial data points to completely diagnose the magnitude of the problem, our review of the limited examples provided by QCC staff has validated this concern. It is unavoidable given a claims-level analytic structure for the data. That is, given BCBSMA current membership (and the fact that we provided the QCC with our ASC claims while other payers did not), for any given provider and any given service, BCBSMA will typically represent at least 50% of the claims. Thus, by design, a claims-level analytic structure will typically have a BCBSMA claim sitting at the 50th percentile – and thus, become the reported amount for that service with that provider.

This is the very problem that the agency was mandated to avoid; its governing statute requires that the QCC guard against "anti-competitive conduct; and . . . the release of data that could reasonably be expected to increase the cost of health care." Such an approach may, in fact, exacerbate the price-elevating effects that several economists have already cautioned might otherwise occur with the public reporting of cost data, as providers across the state would be plainly aware of BCBSMA's negotiated rates by service and provider. By contrast, there are other ways to avoid this anti-competitive result while providing helpful transparency to the consumer. As but one example, using a product-level analysis, any of the state's plan-products might sit at the 50th percentile – moreover, this data point will vary by provider and by service, based on different negotiated deals by different plans for their products. This approach is also entirely consistent with the QCC's goal of affording consumers data by which to compare hospitals on the basis of differences in their rates for specific services, without having the unintended consequence of a claims-level analysis.

Moreover, there do not appear to be any significant time delays from any such analytical change since the data elements submitted by the plans, in accordance with the QCC's regulations, provide both the product type and the information required to define contracted rates for a given service at a given provider. Accordingly, proposed revisions would not involve any changes at all to the planned report formats or displays (only the underlying data points would change). Thus, the public launch of this information would not be significantly delayed from its current status.

In conclusion, while we have been allowed to review only a small set of examples, this limited examination has confirmed that the present analytical plans pose serious anti-competitive effects and also compromise the QCC's goal of providing consumers with provider-specific differences in rates (costs) for specific health care services. Even with efforts to blur the information (e.g., through rounding the cost data prior to reporting), we believe this will remain the case. As such, we respectfully request that the QCC choose a more satisfactory analytic structure, such as the product-level analysis we have suggested. In addition, regardless of the final approach that is taken, it is imperative that prior to the public reporting of that data, BCBSMA (and other health plans) have ample opportunity to review and comment upon data containing plan-specific rate information that will be publicly reported.

Thank you for your time. We look forward to a constructive dialogue on this matter so that we can arrive at a result that serves the twin goals of providing helpful data to the health care consumer while protecting information that may prove anti-competitive to the health care community.

Sincerely,

Andrew Dreyfus
Executive Vice President
Health Care Services

John J. Curley
Senior Vice President
Public, Government & Regulatory Affairs

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To: Katharine London and John Freedman

From: Dana Gelb Safran

Date: 14 August 2008

Subject: Analysis underlying public reporting of cost data

I am following up on the conversation that we had last week, in which I verified with you my understanding of the analytics that underlie the planned approach to public reporting of cost data by the QCC. As promised, I have taken some time to think through the approach – and in fact have done some modeling that I believe is quite helpful. I will summarize it here, and then plan to follow up with an in-person discussion.

As we discussed last week, the current plan involves comparison of median hospital cost for a given service (e.g., colonoscopy) to the statewide median cost for that service. The number of dollars signs shown for a hospital will be based on how its median cost for that service compares with the state – and the member will probably be able to drill down to see the specific amount that constitutes the median cost at that hospital (and possibly some high and low comparison amounts as well). The goal is to assist the public in comparing the cost of the service across various hospitals from which they might choose. The analysis is based on "claims-level" data – so if hospital A has done 10,000 colonoscopies, and hospital B has done 5,000 – then the claims amounts attached to each hospitals' colonoscopies performed will be the basis for determining their "median cost".

By conducting the analysis at the claims level, as opposed to at the product level, I believe the resulting information for public reporting is problematic for a number of reasons. Most importantly, this analytic structure produces information that does not optimally serve the QCC's principal goal of informing individuals about what a service costs at hospital A vs. B. The attached tables illustrate this point with a simulation.

The following illustrative simulation assumes that the procedure we are comparison shopping for is a colonoscopy, that there are 3 hospitals in the state, and that there are 16 "products" in the state (offered by various plans – with some plans offering more than 1 product, like an HMO and a PPO). True to 'real life,' a hospital's negotiated rate with a hospital will differ by product (HMO, PPO, indemnity), but within a hospital, any patient from that plan-product will have the same claim amount in the dataset.

In Table 1, each of the 3 hospitals has done 10,000 colonoscopies – with varying numbers across the 16 plan-products. Based on this set of claims, each hospital has a median cost, as shown, and the state, too, has a median cost. Table 2 uses the identical dataset, but analyzes the data at the "product level" instead of at the claims level. Thus, there are 16 observations for each hospital – one for each product (because each product has a negotiated rate). Based on this set of products, each hospital has a median cost, as shown, and the state, too, has a median cost.

The simulation highlights two important features of the claims vs. product level analysis. First, in the claims-level analysis, a hospital's publicly reported "cost" for colonoscopy is driven by both its negotiated rates for different plan-products (e.g., BCBSMA HMO vs. PPO) and the mix of patients seen across these various products. By contrast, in the product-level analysis, a hospital's publicly reported "cost" for colonoscopy is based entirely on the set of negotiated rates that hospital has for its set of plan-products. The latter produces a piece of information that is wholly consistent with the QCC goal of allowing the public to compare the cost of the service (colonoscopy) across various hospitals from which they might choose. And as illustrated by Tables 1 and 2, the two analyses produce very different results (median cost). The claims-level analysis makes Hospital 2 appear to be the most expensive (median cost=$350) – but that is driven by the fact that they have done almost one-third of their colonoscopies on individuals with a product for which they have a high negotiated rate. By contrast, in the "product level" analysis, hospital 2 has substantially lower median cost ($230) and its standing relative to the state median and the other hospitals is quite different from the claims-level view. This helps to illustrate how a claims-level analysis of these data unnecessarily distorts the information that the QCC seeks to provide to the public – information that allows a member of any plan/product to know how the hospital or provider's cost (negotiated rates) compare with others, and to inform their choice of provider. Claims-level analysis distorts this information by blending in the particular number/mix of patients across products that a provider has served – which is not relevant to the decision making of the member of the public who is seeking care.

A second problematic feature of the claims vs. product-level analysis is that the former will nearly always result in the public reporting of rates negotiated between BCBSMA specifically and each provider. That is, because more than 50% of the claims for any given provider and any given service will come from BCBSMA members, the data point sitting at the 50th percentile of any claims-level analysis will virtually always be a BCBSMA-negotiated rate with that provider for that service (given present membership levels). By contrast, in the product-level analysis, any of the 16 plan-products might sit at the 50th percentile – and that will vary by provider and by service, based on different negotiated deals by different plans for their products. This approach is consistent with the QCC intention of affording consumers data by which to compare hospitals on the basis of differences in their rates for specific services. By contrast, the claims-level analysis produces a type of BCBSMA-specific transparency was not what the state had in mind for this endeavor and that creates serious confidentiality and competitive issues. Among other concerns, the latter method could exacerbate the price-elevating effects that several economists have already cautioned might occur with public reporting of cost data, as providers across the state would be plainly aware of BCBSMA's negotiated rates by service and provider.

The proposed revision to the analytic approach would not involve any changes at all to the planned report formats or displays. Only the analytics behind those displays would be changed. I hope you find this information helpful and clear. I look forward to the opportunity to meet with you to discuss further.

Dollar amounts used in this modeling are NOT based on actual rates. They are entirely made up for purposes of this modeling exercise.

Table 1. Cost of a Colonoscopy Claim for Three Hospitals in Massachusetts (Claim Level)
(n=30,000 total claims – equally divided across 3 hospitals)

	Hospital 1		Hospital 2		Hospital 3	
Plan/Product	Number of claims	Cost per claim	Number of claims	Cost per claim	Number of claims	Cost per claim
Aetna HMO/POS	300	$ 225.00	500	$ 90.00	150	$ 150.00
Aetna PPO	250	$ 500.00	300	$ 200.00	100	$ 350.00
BCBSMA HMO/POS	2500	$ 200.00	3000	$ 350.00	3500	$ 175.00
BCBSMA Indemnity	1000	$ 300.00	500	$ 600.00	1500	$ 900.00
BCBSMA PPO	2500	$ 250.00	2500	$ 400.00	1000	$ 200.00
BCBSRI POS	150	$ 210.00	50	$ 145.00	200	$ 160.00
CIGNA HMO/POS	200	$ 100.00	400	$ 250.00	150	$ 225.00
Connecticut General of Mass/RI PPO	150	$ 550.00	300	$ 700.00	100	$ 450.00
ConnetiCare of Mass HMO/POS	200	$ 150.00	100	$ 180.00	100	$ 100.00
Fallon HMO/POS	400	$ 205.00	100	$ 210.00	150	$ 215.00
Harvard Pilgrim HMO/POS	500	$ 220.00	600	$ 110.00	1000	$ 210.00
Harvard Pilgrim PPO	400	$ 350.00	300	$ 650.00	100	$ 410.00
Neighborhood Health Plan HMO	300	$ 175.00	200	$ 105.00	150	$ 85.00
Tufts HMO/POS	550	$ 280.00	1000	$ 205.00	900	$ 335.00
United HealthCare NE HMO/POS	300	$ 325.00	50	$ 375.00	100	$ 110.00
United HealthCare NE PPO	300	$ 390.00	100	$ 500.00	800	$ 480.00
15th percentile		$ 200.00		$ 200.00		$ 175.00
50th percentile (Median Cost)		$ 250.00		$ 350.00		$ 200.00
85th percentile		$ 300.00		$ 400.00		$ 543.00
STATEWIDE (Represents total of 3 example hospitals)						
15th percentile		$ 175.00				
50th percentile (Median Cost)		$ 250.00				
85th percentile		$ 400.00				

Dollar amounts used in this modeling are NOT based on actual rates. They are entirely made up for purposes of this modeling exercise.

Table 2. Cost of a Colonoscopy Claim for Three Hospitals in Massachusetts (Product Level)
(n=16 total products)

Plan/Product	Hospital 1	Hospital 2	Hospital 3
Aetna HMO/POS	$ 225.00	$ 90.00	$ 150.00
Aetna PPO	$ 500.00	$ 200.00	$ 350.00
BCBSMA HMO/POS	$ 200.00	$ 350.00	$ 175.00
BCBSMA Indemnity	$ 300.00	$ 600.00	$ 900.00
BCBSMA PPO	$ 250.00	$ 400.00	$ 200.00
BCBSRI POS	$ 210.00	$ 145.00	$ 160.00
CIGNA HMO/POS	$ 100.00	$ 250.00	$ 225.00
Connecticut General of Mass/RI PPO	$ 550.00	$ 700.00	$ 450.00
ConnetiCare of Mass HMO/POS	$ 150.00	$ 180.00	$ 100.00
Fallon HMO/POS	$ 205.00	$ 210.00	$ 215.00
Harvard Pilgrim HMO/POS	$ 220.00	$ 110.00	$ 210.00
Harvard Pilgrim PPO	$ 350.00	$ 650.00	$ 410.00
Neighborhood Health Plan HMO	$ 175.00	$ 105.00	$ 85.00
Tufts HMO/POS	$ 280.00	$ 205.00	$ 335.00
United HealthCare NE HMO/POS	$ 325.00	$ 375.00	$ 110.00
United HealthCare NE PPO	$ 390.00	$ 500.00	$ 480.00
15th percentile	$ 181.25	$ 118.75	$ 120.00
50th percentile (Median cost)	$ 237.50	$ 230.00	$ 212.50
85th percentile	$ 380.00	$ 575.00	$ 440.00
STATEWIDE (Represents total of 3 example hospitals)			
15th percentile	$ 145.25		
50th percentile (Median Cost)	$ 222.50		
85th percentile	$ 478.50		